

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

24-1323

85

17284

1. PLACE OF DEATH

County Buchanan Registration District No. 1001
Township Washington Primary Registration District No. 1001
City St. Joseph (No. 1016 Dewey Ave St. 582 Ward)

File No. 17284
Registered No. 582

2. FULL NAME

Gertrude Irene Caster
(a) Residence. No. 1016 Dewey Ave Ward. 5
(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. 4 mos. 0 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 3 1916

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
13 4 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School girl
(b) General nature of industry, business, or establishment in which employed (or employer) Humbolt School
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Joseph
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER B. H. Caster

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Missouri
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Grace Turner

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Missouri
(STATE OR COUNTRY)

14. INFORMANT Mrs. B. H. Caster
Address 1016 Dewey Ave

15. FILED 6 1929 REGISTRAR J. H. [Signature]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 3 1929

17. I HEREBY CERTIFY, That I attended deceased from March 12 1929 to May 3 1929 that I last saw her alive on May 3 1929 and that death occurred, on the date stated above, at 9:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia (Chronic)
92 Inflammatory
57A

CONTRIBUTORY (SECONDARY) Endocarditis
Chronic (duration) 3 yrs. 0 mos. 0 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

0 DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) W. H. [Signature], M. D.

Address St. Joseph, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Ashland Cemetery DATE OF BURIAL May 6 1929

20. UNDERTAKER E. G. Eidenfaden ADDRESS 6020 E. 10th

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

